

## Direct Reimbursement Dental Plan Enrollment Form

Name of Company: \_\_\_\_\_

Coverage Elected:   Employee   Employee & Spouse   Employee & Child   Family

Name of Employee: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Complete this section only if you are electing dependent coverage:

Spouse's Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Children Name	SS#	Date of Birth	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any other Dental Insurance?   Yes   No

If yes, please Specify: \_\_\_\_\_

If you are married and have coverage through your spouse, please complete the following:

Spouses Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Telephone # \_\_\_\_\_

I hereby apply for dental benefits under my employer's plan. I am aware that:

1. I am enrolling for coverage now and realize I cannot change my election until the next enrollment period unless there is a change in family status.
2. I hereby authorize my contributions to the plan, if any, be withheld from my paycheck.

By my signature below, I represent that all information shown on this form is correct.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

### Employer must complete

Date of Hire \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_ Late Applicant?    Yes    No